

1 KAMALA D. HARRIS  
Attorney General of California  
2 KAREN B. CHAPPELLE  
Supervising Deputy Attorney General  
3 WILLIAM D. GARDNER  
Deputy Attorney General  
4 State Bar No. 244817  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 897-2114  
6 Facsimile: (213) 897-2804  
*Attorneys for Complainant*  
7

8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2013-504*

13 **GEOFFREY RAYMOND WEST**  
14 **1358 Harold Avenue**  
15 **Simi Valley, CA 93065**

**A C C U S A T I O N**

16 **Registered Nurse License No. 632296**

Respondent.

17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
20 official capacity as the Executive Officer of the Board of Registered Nursing, Department of  
21 Consumer Affairs.

22 2. On or about February 10, 2004, the Board of Registered Nursing issued Registered  
23 Nurse License Number 632296 to Geoffrey Raymond West (Respondent). The Registered Nurse  
24 License was in full force and effect at all times relevant to the charges brought herein and will  
25 expire on January 31, 2014, unless renewed.

26 ///

27 ///

28 ///

1

2

5

9

2

## 4

5

6

8

9

1

2

3

6

1 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as  
2 defined in Section 4022.

3 ...

4 "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any  
5 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this  
6 section."

7 9. California Code of Regulations, title 16, section 1443, states:

8 "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the  
9 failure to exercise that degree of learning, skill, care and experience ordinarily possessed and  
10 exercised by a competent registered nurse as described in Section 1443.5."

#### 11 COST RECOVERY

12 10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
13 administrative law judge to direct a licentiate found to have committed a violation or violations of  
14 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
15 enforcement of the case, with failure of the licentiate to comply subjecting the license to not being  
16 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be  
17 included in a stipulated settlement.

#### 18 DRUG STATUTES

19 11. **Dilaudid** is a brand name for Hydromorphone, which is a Schedule II controlled  
20 substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J), and is  
21 categorized as a dangerous drug pursuant to section 4022.

22 12. **Morphine/morphine sulfate** is a Schedule II controlled substance as designated by  
23 Health and Safety Code section 11055, subdivision (b)(1)(L), and is categorized as a dangerous  
24 drug pursuant to section 4022.

25 ///

26 ///

27 ///

28 ///

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct: Obtain Controlled Substance Unlawfully)**

3 13. Respondent is subject to disciplinary action under section 2762, subdivision (a), in  
4 that Respondent obtained a controlled substance in violation of the law. The circumstances are as  
5 follows:

6 a. On or about March 10, 2011, while working as a registered nurse in the emergency  
7 room at Pacifica Hospital of the Valley, Respondent surreptitiously used the log-in code of  
8 another employee, charge nurse R.D., to withdraw a 4 mg vial of Dilaudid from the Omnicell  
9 narcotics dispensing machine purportedly for Patient E.A.<sup>1</sup> In addition, Respondent falsely  
10 documented that a physician had ordered the Dilaudid for Patient E.A., when in fact no such order  
11 had been given. After being confronted with this unlawful diversion of Dilaudid, Respondent  
12 abruptly resigned his position at the hospital. A subsequent investigation into all of Respondent's  
13 Omnicell activity from January 2011 through March 2011 evidenced additional instances of drug  
14 diversion by Respondent, as follows.

15 b. On or about March 8, 2011, Respondent withdrew a 1 mg ampule of Dilaudid at 2115  
16 for Patient M.C. At that time, there was no physician order to administer Dilaudid to Patient  
17 M.C., yet Respondent removed the Dilaudid from the Omnicell and charted that it had been  
18 administered to Patient M.C. Roughly an hour later, at 2221 on March 8, 2011, Respondent  
19 withdrew another 1 mg ampule of Dilaudid from the Omnicell, which was also to be administered  
20 to Patient M.C. At that time, there was no physician order to administer Dilaudid to Patient M.C.  
21 In addition, Respondent failed to chart that he administered the second dose of Dilaudid to Patient  
22 M.C. Respondent later noted in the patient's chart that a verbal order for 1 mg of Dilaudid was  
23 given by Dr. Az at 2230; however, the purported order, which would have been made after  
24 Respondent withdrew and administered the Dilaudid, was not countersigned by Dr. Az.

25 ///

26 <sup>1</sup> The Omnicell system is an automated medication dispensing machine which requires an access  
27 code and PIN and which records pertinent information about transactions, including the identity of the  
28 individual withdrawing the medication, the time and date of the withdrawal, the medication dispensed, the  
patient to whom the medication is being administered and the name of the ordering physician.

1 c. On or about January 31, 2011, Respondent withdrew 4 mg of Dilaudid pursuant to a  
2 physician order calling for 4 mg of Dilaudid Intramuscular to be administered to Patient T.W.  
3 Respondent charted that he administered the 4 mg of Dilaudid to Patient T.W. as directed.  
4 Respondent then documented a purported verbal order from Dr. Ab for an additional 2 mg of  
5 Dilaudid, with no time or route indicated. Respondent then removed another 4 mg of Dilaudid  
6 and charted that he administered 2 mg to Patient T.W. twenty (20) minutes before the patient was  
7 discharged despite the fact that the nursing notes do not support that Patient T.W. was in pain  
8 prior to discharge. In addition, Respondent failed to document that the remaining 2 mg of  
9 Dilaudid was wasted.

10 d. On or about January 15, 2011, Respondent withdrew one 4 mg vial of morphine  
11 sulfate and one 2 mg vial of morphine sulfate pursuant to a physician order calling for the  
12 administration of 4 mg of morphine sulfate to Patient A.O. Respondent then charted that he  
13 administered 4 mg of Dilaudid to patient A.O., but he failed to document that he wasted the extra  
14 2 mg vial of morphine sulfate that he had removed from the Omnicell.

#### 15 **SECOND CAUSE FOR DISCIPLINE**

##### 16 **(Unprofessional Conduct: False/Grossly Incorrect Entries Related to Narcotics)**

17 14. Respondent is subject to disciplinary action under section 2762, subdivision (e), in  
18 that Respondent made false and/or grossly inaccurate entries in records pertaining to controlled  
19 substances. The circumstances are as follows:

20 a. On or about February 8, 2011, Respondent removed one 4 mg vial of morphine  
21 sulfate and one 2 mg vial morphine sulfate pursuant to a physician order that 10 mg of morphine  
22 sulfate be administered to Patient J.W. Despite withdrawing only a total of 6 mg of morphine  
23 sulfate, Respondent documented in his charting that the 10 mg dose ordered by the physician was  
24 administered to Patient J.W.

25 b. Complainant refers to, and by this reference incorporates, the allegations set forth  
26 above in paragraph 13, subdivisions a through d, inclusive, as though set forth fully herein.

27 ///

28 ///

1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct: Incompetence)**

3 15. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), in  
4 conjunction with California Code of Regulations, title 16, section 1443, in that Respondent  
5 demonstrated a lack of possession and/or failure to exercise the degree of learning, skill, care and  
6 experience ordinarily possessed and exercised by a competent nurse. Complainant refers to, and  
7 by this reference incorporates, the allegations set forth above in paragraph 13, subdivisions a  
8 through d, and paragraph 14, subdivisions a and b, inclusive, as though set forth fully herein.

9 **PRAYER**

10 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
11 and that following the hearing, the Board of Registered Nursing issue a decision:

12 1. Revoking or suspending Registered Nurse License Number 632296, issued to  
13 Geoffrey Raymond West;

14 2. Ordering Geoffrey Raymond West to pay the Board of Registered Nursing the  
15 reasonable costs of the investigation and enforcement of this case, pursuant to Business and  
16 Professions Code section 125.3;

17 3. Taking such other and further action as deemed necessary and proper.  
18  
19

20 DATED: December 19, 2012 *for* *Amie Ben*  
21 LOUISE R. BAILEY, M.ED., RN  
22 Executive Officer  
23 Board of Registered Nursing  
24 Department of Consumer Affairs  
25 State of California  
26 Complainant

25 LA2012508070  
26 51189758.doc  
27  
28